PRINTED: 10/19/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM | | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | | |
|---|---|--|---|---|---|------------|--------------------------|--|--|
| | | | | A. BUILDING B. WING | <u> </u> | | C | | |
| NVS1214SNF | | NVS1214SNF | T | | | 10/07/2009 | | | |
| VEGAS VALLEY DEHABILITATION HOSPITAL | | | 2945 CASA | DDRESS, CITY, STATE, ZIP CODE SASA VEGAS STREET GAS, NV 89109 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE | | |
| Z 000 Initial Comments | | | | Z 000 | | | | | |
| | Surveyor: 26855 | | | | | | | | |
| | a result of complaint your facility on 10/06, 10/07/09, in accordant Administrative Code, Skilled Nursing. Complaint #NV00022 Complaint #NV00022 deficiencies cited. (See Tags # Z064 and A Plan of Correction The POC must relate and prevent such occintended completion.) | nce with Nevada Chapter 449, Facilities 2951 was unsubstantia 2952 was substantiated | d in for ted. I with red. nts The sm(s) | | | | | | |
| | Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. | | | | | | | | |
| | by the Health Division prohibiting any criminactions or other claim | clusions of any investion shall not be construent or civil investigation or for relief that may be under applicable fede | d as s, | | | | | | |
| | The following deficier | ncies were identified: | | | | | | | |
| Z 64 SS=D | NAC 449.74429 Tran | nsfer or Discharge of Pa | atient | Z 64 | | | | | |
| | patient for his transfe | I nursing shall prepare er or discharge in such the safe and orderly tr | а | | | | | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | | · ' | (X3) DATE SURVEY COMPLETED C | | | |
|---|---|--|--|---|---|--|--|--|--|
| | | | 1 | | | | | | |
| NVS1214SNI | | B. WING | | | 10/07/2009 | | | | |
| NAME OF PROVIDER OR SUPPLIER STR | | | | TE, ZIP CODE | - | | | | |
| VEGAS VALLEY REHABILITATION HOSPITAL | | | 2945 CASA VEGAS STREET LAS VEGAS, NV 89109 | | | | | | |
| OLIMANA DV. OT | ATEMENT OF DEFICIENCIES | | | DDO//DEDIO DI ANI OF O | ODDECTION | | | | |
| (EACH DEFICIENCY MUST BE PRECEDED BY FU | | | PREFIX (EACH CORRECTIVE ACTION S | | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | | | |
| Continued From page 1 | | | Z 64 | | | | | | |
| or discharge of the patient from the facility. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and facility discharge policy and procedure review, the facility failed to ensure the safe and orderly discharge of a confused elderly resident diagnosed with dementia from the facility. (Resident #2) | | | | | | | | | |
| Severity: 2 Scope: 1 | | | | | | | | | |
| Complaint #NV00022 | 2952 | | | | | | | | |
| NAC449.74493 Notification of Changes or Condition | | | Z310 | | | | | | |
| 1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accident and may require treatment from a physician; (b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life; (c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharged from the facility; (e) The patient will be assigned to another room or assigned a new roommate; or (f) There is any change in federal or state law that affects the rights of the patient. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document | | | | | | | | | |
| | SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page or discharge of the pa This Regulation is no Surveyor: 26855 Based on interview, r discharge policy and failed to ensure the s a confused elderly re dementia from the fact Severity: 2 Scope: Complaint #NV00022 NAC449.74493 Notific Condition 1. A facility for skilled notify a patient, the p or an interested mem known, and, if approp physician, when: (a) The patient has be and may require treat (b) The patient has be and may require treat (c) There is a need to treatment of the patie complications or is th (c) There is a need to treatment of the patie consequences cause commence a new typ (d) The patient will be from the facility; (e) The patient will be or assigned a new ro (f) There is any chang affects the rights of th This Regulation is no Surveyor: 26855 Based on interview, r | NVS1214SNF ROVIDER OR SUPPLIER ALLEY REHABILITATION HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FL REGULATORY OR LSC IDENTIFYING INFORMATION This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and facility discharge policy and procedure review, the failed to ensure the safe and orderly discharge a confused elderly resident diagnosed with dementia from the facility. (Resident #2) Severity: 2 Scope: 1 Complaint #NV00022952 NAC449.74493 Notification of Changes or Condition 1. A facility for skilled nursing shall immediat notify a patient, the patient's legal representa or an interested member of the patient's fam known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accide and may require treatment from a physician; (b) The patient's physical, mental or psychos health has deteriorated and resulted in medi complications or is threatening the patient's local formations or is threatening the patient's local formations or is threatening the patient's local formations or is threatening the patient's local from the facility; (c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharge from the facility; (e) There is any change in federal or state law affects the rights of the patient. 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PRINTED: 10/19/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS1214SNF 10/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2945 CASA VEGAS STREET **VEGAS VALLEY REHABILITATION HOSPITAL** LAS VEGAS, NV 89109 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z310 Continued From page 2 Z310 patients legal representative or family member that the resident, who was an elderly confused resident diagnosed with dementia, was being discharged from the facility and failed to appropriately transfer the care and protective custody of the resident to a responsible family member. (Resident #2) Severity: 2 Scope: 1 Complaint #NV00022952

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